PROCEDURAL GUIDANCE FOR IMPLEMENTATION OF SAFETY COUNTS

CBO PROGRAM ANNOUNCEMENT RFP 04064
DEPARTMENT OF HEALTH AND HUMAN SERVICES

DESCRIPTION OF SAFETY COUNTS

Safety Counts is a cognitive-behavioral intervention to reduce HIV risks among active drug users and specifically targets active crack cocaine and injection drug users who are at very high risk for HIV/STD infection.[1] An important component of Safety Counts is recruitment, used to link clients to counseling, testing and referral, prevention and treatment services, care and other support services. Safety Counts is used with both HIV positive and HIV negative clients. This intervention has been packaged by CDC's Diffusion of Effective Behavioral Interventions (DEBI) project and information on obtaining the intervention training and materials is available at www.effectiveinterventions.org.

The primary objective of the intervention is to reduce HIV transmission among intravenous drug users (IDUs) and crack users who are not in treatment. The program also strives to increase the understanding of drug use patterns in relation to HIV infection risk as well as monitor HIV seroprevalence among drug users. The program consists of seven sessions held over four months: two group sessions, one individual counseling session, two (or more) group social events, and two (or more) follow-up contacts. The intervention uses incentives to encourage participation. Safety Counts also utilizes structured and unstructured psychoeducational activities in individual and group sessions.

The intervention incorporates social modeling, social support, and modified behavioral contracting. *Safety Counts* clients design and manage their own personal HIV risk-reduction plan with the support and guidance of counselors and outreach staff. This allows clients to recognize how their own behaviors may put them at risk for HIV, hepatitis C, other blood borne and sexually transmitted diseases; figure out for themselves what they can reasonably do to reduce their risk for HIV and hepatitis C; take ownership of their personal risk-reduction goals; and develop and manage solid plans for achieving those goals.

By engaging the client in group and individual sessions, *Safety Counts* helps form a partnership between the client and agency staff. This client-centered approach not only assists in reducing HIV risk behaviors and infection of clients, but also can have other benefits including reductions in drug use and increased entry into drug treatment for clients and their peers.

Research showed that participants in the intervention group were more likely to report an increase in condom use at follow-up (5-9 months after enrollment) compared to those in the

comparison group. Participants in the intervention group compared to the comparison group also reported they had stopped using crack, stopped injecting drugs, had reduced injection drug use, and fewer crack users tested positive for cocaine at follow up.[1]

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements are those components that are critical features of an intervention or strategy's intent and design and that are thought to be responsible for its effectiveness. Consequently, they must be maintained without alteration to ensure program effectiveness. Core elements are derived from the behavioral theory upon which it the intervention or strategy is based. They are essential to the implementation of the program and cannot be ignored, added to, or changed. Safety Counts has 4 core elements:

1) Two group sessions (identify client's HIV risks and current stage of change, hear risk-reduction success stories, set personal goal and identify first step to reduce HIV risk).

2) One individual counseling session (discuss/refine risk-reduction goal, assess client's needs and provide indicated referrals to C&T and medical/social services).

3) Two (or more) group social events (share meal and socialize, participate in planned HIV-related risk-reduction activities, receive reinforcement for personal risk reduction).

4) Two (or more) follow-up contacts (review client's progress in achieving risk-reduction goal, discuss barriers encountered, identify concrete next step and discuss possible barriers/solution, make referrals to C&T, and medical/social services).

Key Characteristics are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations to meet the needs of the target population and ensure cultural appropriateness of the strategy. Key characteristics of Safety Counts are:

- The content of group social event must contain a planned, HIV-related risk-reduction component but the activity can be educational games or workshops, roundtables or featured speakers
- The video of risk-reduction success stories, provided in the Safety Counts kit, is a copy of the one used in the original intervention showing how local drug users were able to successfully adopt sex- and drug-related risk-reduction strategies. Agencies implementing Safety Counts are strongly encouraged to make their own videos using individuals from their local communities to increase the authenticity of the risk-reduction success stories. Alternatively, agencies may choose to produce audio tapes or written stories, or arrange for live testimonials describing personal risk-reduction successes. Live testimonials are considered to be the least desirable mechanism because of their uncontrolled nature
- The length of the individual contracting session can be increased from the recommend time of 15-30 minutes

Procedures describe the activities that make up the content of the intervention and provide direction to agencies or organizations regarding the conduct of the intervention. Procedures for implementing Safety Counts follow below:
As a result of the activities in this intervention, voluntary counseling and testing is offered to clients. If the implementing agency already offers counseling and testing, then this intervention fits in well with these services. If not, provide active referrals to agencies that do provide counseling and testing. Although HIV testing is not required before attending the first intervention session, clients who have not recently been tested should be encouraged to get tested and learn their status as soon as possible.

Peer recruitment and outreach is an important component of Safety Counts. Clients who participate in the intervention recruit their peers into the group sessions. Once a peer enrolls in the Safety Counts program, they are encouraged to seek counseling and testing for HIV, hepatitis C and other infectious diseases as soon as possible, preferably on site. Staff also refer clients to prevention and treatment services, drug treatment services, shelter and other social, medical and support services.

General tips on the procedures for implementing Safety Counts include:

- Meeting space that is comfortable and inviting and may allow participants to smoke
- Intervention times and locations that are consistent (i.e., same time and place), convenient and don't conflict with participants' other responsibilities or needs
- Intervention sessions (especially groups and socials) that are lively and developed with plenty of input from participants themselves
- Programming that creates a dependable environment of trust and respect
- Programming that strictly maintains confidentiality
- Programming that includes the capacity to refer participants to other services (domestic abuse agencies, rape counseling, and mental health)

Specific guidance on procedures for implementing Safety Counts includes:

Group Sessions 1 and 2 (One Session Each)

The group sessions use a stages-of-change framework to help clients identify their personal stage of change. They are an opportunity for clients to talk with peers and agency staff about risk behaviors and prevention methods. The sessions establish that personal risk reduction is relevant, needed, and achievable. Clients think about how risk behaviors apply to them and begin a process to reduce a particular risk. Within the group sessions, the clients set a personal goal for reducing HIV risk and decide on a first step toward meeting that goal.

Individual Behavioral Counseling (One Session Minimum)

The individual behavioral counseling session, which is conducted after the group sessions, gives clients an opportunity to reflect on their personal risk-reduction goals and barriers to goal achievement. Clients work with counselors to revise their goals if they are unrealistic or too

difficult to achieve, and to determine more achievable, smaller steps toward risk reduction. They may also find that the goals they set were easily achievable, and be ready to set more challenging goals. In either case, individual sessions allow for the intimacy of discussing risk-taking behavior in more detail in confidentiality. This session also provides an opportunity to build rapport between the counselor—who acts as a supporter—and the client. Finally, the individual session is an opportunity for assessing a client's needs and ensuring referrals for medical and support services.

Social Events (Two Minimum)

The *Safety Counts* intervention calls for clients to attend a minimum of two social events following their participation in the group session. The social events must have a planned HIV-related risk reduction activity such as a game, workshop or speaker. The socials, which are typically offered on a monthly basis, provide an opportunity to strengthen clients' relationships to the program, to agency staff, and to peers. In a less formal setting, with a meal provided, clients are given support for their progress in achieving personal risk-reduction goals. Clients are also encouraged to invite friends and family members. These socials can help motivate clients to complete the full seven-session intervention.

Follow-up Contacts (Two Minimum)

Outreach workers conduct at least two supportive follow-up contacts with clients subsequent to the individual counseling session. These encounters are structured and planned in advance with input from other agency staff who have worked with the client. Follow-up encounters may be conducted in the office, on the street, in the home, or elsewhere in the community. The purpose is to review risk-reduction progress made by the client and to encourage achievement of the client's personal risk-reduction goal. Outreach staff reinforce the client's risk-reduction efforts, assess his or her progress, and offer strategies to overcome reported barriers. At this time, referrals for social, medical, drug treatment, shelter, and other support services are again offered as needed.

RESOURCE REQUIREMENTS

Like most interventions of its kind, the effectiveness of *Safety Counts* depends on the people who implement it. Team members must be sensitive, skilled, and knowledgeable about the drug-using culture and its various populations. Besides the executive director of the implementing agency, Safety Counts requires at least four team members:

- One program manager
- Two outreach workers, working as a pair in an outreach team
- One behavioral counselor who can facilitate group and individual sessions and socials

Resources permitting, more than two outreach workers and, preferably, more than one counselor should be used for the intervention. The counselor does not need to be a licensed professional; a trained paraprofessional can work very well. The more outreach teams put into the field, the

greater numbers of drug users will be accommodated through the *Safety Counts* intervention. Some basic administrative support is helpful, if available. Management of the intervention will be easier if all team members are responsible to a single organization, but there may be cases where agencies pool human resources and partner with other agencies.

In addition to the intervention team, other program resources that are necessary to implement *Safety Counts* include:

Transportation for Clients and Outreach Workers: Transportation could include the organization's van, another organization's van used by agreement, personal cars, and public transportation. In some localities, use of a van for other than personal purposes to transport multiple individuals requires the driver to be a licensed chauffeur. Use of personal cars requires the driver to assume liability for any accidents. Adequate and up-to-date insurance is required for all means of transportation (other than public).

Outreach Materials: These can include anything already used in outreach activities to active drug users or new materials developed especially for *Safety Counts*.

Collaborative Partnerships with Other Organizations: These include partnerships with other organizations to provide component parts of *Safety Counts* if all components cannot be delivered by the primary agency.

Incentives for Clients: These are the "perks" that will help retain clients in *Safety Counts* activities. Incentives such as cash and food should be used whenever possible to recruit clients and maintain their participation in the program. Other types of incentives include: meals at meetings, raffles (e.g., enroll at recruitment with proviso that to win, participant must remain in the interventions), condoms, feminine hygiene products, free or reduced-fee childcare, free or reduced-fee transportation to or from meetings, food and clothing vouchers, hot showers or a place to clean up. Ideally, a combination of the incentives listed above will result in recruitment and retention of participants. As time goes on, participants may identify other incentives that may be more desirable.

A Referral Network in Place for Client Needs that the Organization Cannot Address, Especially HIV Counseling and Testing Services: This may be a network already in place or a new network to be developed. Agencies must be certain that they have specific referral information for clients; i.e., the name of the appropriate staff person at the other agency and that the agency provides high-quality services. Staff should follow up with the client and the other agency about whether action occurred on the referral.

The cost of implementing *Safety Counts* will vary based on regional and local differences in salaries, transportation costs, the cost of various goods and services, and other factors. However, the cost of *Safety Counts* can be significantly reduced if supplies (condoms), services (food preparation) and incentives (food vouchers) are donated rather than purchased. Local suppliers, caterers, grocers, food banks and restaurants, movie theatres, clothing outlets, drugstores, museums, media outlets, public transportation authorities, taxi companies, and other merchants should all be approached for donations in the preparation phase of program planning.

RECRUITMENT

The recruitment activity is an important component of *Safety Counts*. Primary responsibility for recruiting active drug users into the intervention program rests with the agency's paid outreach staff. Most agencies will be able to use their current outreach workers, with established relationships and linkages to drug-using individuals in the local community, to promote *Safety Counts* and develop interest in the program among members of the target population. It is essential that outreach workers for *Safety Counts* be completely familiar with the local drug-using community, and it is preferable that they be recovering drug users. Agencies that do not have significant experience outreaching to active drug users are encouraged, prior to program implementation, to form a peer advisory panel composed of indigenous current and/or former drug users to guide initial recruitment efforts and provide advice concerning effective participation incentives. (See "Resource Requirements" for a discussion of possible incentives.)

During the recruitment process, outreach workers not only promote the *Safety Counts* program to potential participants, but they are also encouraged to perform a brief assessment of individual needs for medical and social services, including C&T and drug treatment, and to make specific referrals as indicated. Fold-over handout cards describing services in the local area are highly recommended. The needs assessment and referral component of *Safety Counts* recruitment is considered a key benefit of the program.

PHYSICAL SETTING CHARACTERISTICS

Space for Group Meetings: This space should be reliably available when needed. The space should be flexible; i.e., large enough to accommodate group activities such as icebreakers as well as comfortable seating arrangements for large- and small-group activities. Ideally, the group meeting space would come equipped with a VCR, television monitor, and newsprint easels. If these items don't come with the space, they will need to be obtained elsewhere.

Space for Private, One-on-One Counseling Sessions: This space must be a room with a door. Open cubicles or other venues that are not completely private are not appropriate. The private space should have comfortable seating for counselor and client.

NECESSARY POLICIES AND STANDARDS

Before an agency attempts to implement Safety Counts, the following policies and procedures should be in place to protect participants, and the agency:

Targeting of Services: Agencies must establish criteria for, and justify the selection of, the target populations. Selection of target populations must be based on epidemiological data, behavioral and clinical surveillance, and the state or local HIV prevention plan created with input from the state or local community planning group(s).

Safety: Agency policies must exist for maintaining safety of workers and clients. Plans for dealing with medical or psychological emergencies must be documented.

Confidentiality: A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from a client or his/her legal guardian must be obtained.

Linkage of Services: Recruitment and health education and risk reduction must be linked to counseling, testing, and referral services for clients of unknown status, and to care and prevention services for people living with HIV (PLWH). Agencies must develop ways to assess whether and how frequently the referrals made by staff were completed.

Data Security: Collect and report data consistent with CDC requirements to ensure data security and client confidentiality.

Cultural Competence: Agencies must strive to offer culturally competent service by being aware of the demographic, cultural, and epidemiological profile of their communities. Agencies should hire, promote, and train staff across all disciplines to be representative of and sensitive to these cultures. In addition, materials and services must be offered in the preferred language of clients/consumers where possible, or translation should be available if appropriate. Agencies should facilitate community and client/consumer involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care* which should be used as a guide for ensuring cultural competency in programs and services. Please see the Cultural Competence section in the introduction of this document (page 9) for standards for developing culturally and linguistically competent programs and services.

Personnel Policies: Agencies conducting recruitment, outreach, and health education and risk reduction, must established a code of conduct. This code should include, but not be limited to, no drug or alcohol use, appropriate behavior with clients, and no loaning or borrowing of money.

Volunteers: If the agency is using volunteers to assist in or conduct this intervention, then the agency should know and disclose how their liability insurance and worker's compensation applies to volunteers. Agencies must ensure that volunteers also receive the same training and are held to the same performance standards as employees. Agencies must also ensure that volunteers sign and adhere to a confidentiality statement. All training should be documented.

QUALITY ASSURANCE

Successful implementation of Safety Counts requires that team members possess the following attributes:

- Familiarity with the process and logistics of drug use.
- Familiarity with the drug-using culture and its various populations.
- Familiarity with HIV and its prevention.
- Good verbal communication skills.
- Personal characteristics that facilitate communication (e.g., nonjudgmental attitudes, active listener, friendly and outgoing, trustworthy).

A strong component of maintaining program quality is preparing a plan to implement Safety Counts. Developing a comprehensive implementation plan will facilitate understanding and "buy-in" from staff and increase the likelihood the intervention runs smoothly.

Quality assurance on this intervention also requires that someone at the agency will provide hands-on leadership and guidance for the intervention—from preparation through institutionalization. A decision maker is needed in the agency who will provide higher-level support, including securing resources and advocating for Safety Counts, from preparation to institutionalization.

Throughout implementation, it is necessary to determine whether staff is maintaining fidelity to the content of the four core elements: (1) two group workshops; (2) one individual counseling session; (3) two (or more) group social events; (4) two (or more) follow-up contacts. It is also necessary to identify and address any issues to assure the intervention is meeting the needs of agency clients and staff. Staff who are implementing Safety Counts can develop their own Quality Assurance Checklist to help staff identify, discuss and solve problems in successfully implementing the intervention.

The Safety Counts implementation manual provides guidance on developing a plan for program monitoring. The implementation manual provides two suggested forms: a worksheet that supports process evaluation for the program overall and an instrument that measures individual outcomes.

MONITORING AND EVALUATION

Evaluation and monitoring intervention activities include the following:

- Collect and report standardized process and outcome monitoring data consistent with CDC requirements;
- Enter and transmit data for CDC-funded services on PEMS (Program Evaluation Monitoring System), a CDC-provided browser-based system, or describe plans to make a local system compatible with CDC's requirements;
- Collect and report data consistent with the CDC requirements to ensure data quality and security and client confidentiality;
- Collaborate with CDC in assessing the impact of HIV prevention activities by participating in special projects upon request.
- Collect and report data on the following indicators:

- **I.A-** The mean number of outreach contacts required to get one person with unknown or negative serostatus to access counseling and testing.
- **I.B-** The proportion of person who access counseling and testing from each of the following interventions: individual level interventions and group level interventions.
- **IV.A-** Proportion of client records with the CDC-required demographic and behavioral risk information.
- **V.A -** The mean number of outreach contacts required to get a person (living with HIV, their sex partners and injection drug-using contacts or at very high risk for HIV infection) to access referrals made under this program announcement.

KEY ARTICLES AND RESOURCES

[1] Rhodes F, Wood MM, Hershberger S. (2000). A cognitive-behavioral intervention to reduce HIV risks among active drug users. In Staying negative in a positive world: HIV prevention strategies that work (pp. 113-124). Sacramento: California Department of Heath Services, Office of AIDS.

Rhodes F, Humfleet GL. (1993). Using goal-oriented counseling and peer support to reduce HIV/AIDS risk among drug users not in treatment. Drugs & Society (3/4):185-204.

Rhodes F, Humfleet GL, Mowrey-Wood MM, Corby NH. (1993). The behavioral counseling model for injection drug users: Intervention manual (NIH Pub. No. 93-3597). Rockville, MD: National Institute on Drug Abuse.

Rhodes F, Malotte CK. (1996). HIV risk interventions for active drug users: Experience and prospects. In S. Oskamp & S. Thompson (Eds.). Understanding and preventing HIV risk behavior: Safer sex and drug uUse (pp. 207-236). Thousand Oaks, CA: Sage Publications.

Rhodes F, Wood MM, Booth RE. (1998). Efficacy and effectiveness issues in the NIDA Cooperative Agreement interventions for out-of-treatment drug users. Journal of Psychoactive Drugs, 30, 261-268.

Wood,MM, Rhodes F. (1998 April). A cognitive-behavioral intervention to reduce HIV risks among active drug users: Implementation issues. Paper presented at the Staying Negative in a Positive World: HIV Prevention Strategies That Work Conference, Los Angeles.

For more information on the Safety Counts intervention, training and technical assistance, or to get your name on a list for a future training, please go to the website: http://www.effectiveinterventions.org.

PROCEDURAL GUIDANCE FOR IMPLEMENTATION OF THE SISTA PROJECT— A PEER LED PROGRAM TO PREVENT HIV INFECTION AMONG AFRICAN AMERICAN WOMEN

CBO PROGRAM ANNOUNCEMENT RFP 04064
DEPARTMENT OF HEALTH AND HUMAN SERVICES

DESCRIPTION OF SISTA

The SISTA Project—or **S**isters **I**nforming **S**isters **A**bout **T**opics on **A**IDS -- is a social skills training intervention aimed at reducing HIV sexual risk behavior among African American women at highest risk.[1-3] It is composed of five two-hour sessions delivered by peer facilitators in a community based setting. The sessions are gender – and culturally- relevant and include behavioral skills practice, group discussions, lectures, role play, a prevention video, and take home exercises. The five sessions that generate these discussions and activities include Ethnic/Gender Pride; HIV/AIDS Education; Self Assertiveness Skills Training; Behavioral Skills Management; and Coping. This intervention has been packaged by CDC's Diffusion of Effective Behavioral Interventions (DEBI) project and information on obtaining the intervention training and materials is available at www.effectiveinterventions.org.

SISTA applies both the Social Cognitive Theory and the theory of gender and power. According to the Social Cognitive Theory, people need information (HIV risk-information), training in social and behavioral skills, and knowledge of norms to apply risk-reduction strategies. A change in behavior is dependent upon self-efficacy, self confidence, and outcome expectations.

The theory of gender and power is a social structural theory that accounts for gender-based power differences in male-female relationships. It examines, by gender, the division of labor and the distribution of power and authority within relationships and gender-based definitions of sexually appropriate conduct. In addition, the theory considers the impact of a woman's willingness to adopt and maintain sexual risk-reduction strategies within heterosexual relationships as it pertains to her lack of power, her commitment to the relationship and her role in the relationship.

The study was originally implemented with 128 heterosexual women. Results indicated that a social skills training that is delivered in a community setting can positively affect condom use. Specifically, women in the experimental condition reported more condom use than women in the control condition.[1]

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements are those components that are critical features of an intervention's or strategy's intent and design that are thought to be responsible for its effectiveness. Consequently, they must be maintained without alteration to ensure program effectiveness. Core elements are derived from the behavioral theory upon which the intervention or strategy is based. They are essential to the implementation of the program and cannot be ignored, added to, or changed. SISTA has 7 core elements which include:

1) Small group sessions to discuss the session objectives, address the challenges and joys of being an African American woman, model skills development and role play women's skills acquisition.

2) Use of a skilled facilitator to implement the group sessions because the success of the SISTA Program depends on the skill of the facilitator.

3) Use of cultural and gender appropriate materials to acknowledge pride, enhance self worth in being an African American woman (e.g., use of poetry, artwork by African American women).

4) Training of women in sexual assertion skills so that they can both demonstrate care for partners and negotiate safe behaviors.

5) Teaching women proper condom use skills. SISTA is designed to foster positive attitudes and norms towards consistent condom use and provide women the appropriate instruction for placing condoms on their partner.

6) Discussions of the cultural and gender triggers that may make it challenging to negotiate safer sex.

7) Emphasis on the importance of the partner's involvement in safer sex. The homework activities that are included in the SISTA Project are designed to involve the male partner.

Key Characteristics are crucial activities and delivery methods for conducting an intervention, which may be adapted or tailored to meet the needs of the target population in different agencies and ensure cultural appropriateness of the strategy. SISTA has the following key characteristics:

- Flexibility to be tailored for different populations of African American women, for example, women in substance abuse treatment facilities, incarcerated women, women residing in shelters, and sex workers.
- Passion, such that the facilitators can deliver the intervention with conviction and purpose.
- Cultural competency, in that it was developed by African American women and for African American women.

- Broad content that includes discussions not only about HIV prevention, but also about relationships, dating, and sexual health.

Procedures describe the activities that make up the content of the intervention and provide direction to agencies or organizations regarding the implementation of the intervention. Procedures for implementing the SISTA project follow.

The SISTA Project consists of:

- Five once-a-week sessions that are two hours each
- Two booster sessions administered two and four months after the project is completed, also two hours in length. These booster sessions are designed to provide an opportunity for the program participants to ask further questions and/or provide peer support
- A graduation party and a Certificate of Accomplishment for each of the participants after completion of the second booster session

Each of the sessions has a specific goal and objectives. The goals and activities of each of the sessions follow:

Session 1-Ethnic/Gender Pride:

Goal: Generate a discussion about being African-American and female, having pride in oneself, and valuing oneself.

During the first session, the facilitators will:

- Distribute an opening poem that will be read with and/or to the women
- Introduce themselves to the women, introduce the intervention to the women and introduce the women to each other
- Encourage the women to develop ground rules and expectations
- Facilitate a discussion about the positive qualities of black women and how they can be used as a source of strength and pride; conduct a discussion on values, requesting the women to prioritize their personal values
- Encourage the women to complete a simple homework exercise
- Distribute anonymous evaluation forms to assess the first session
- Read a closing poem with and/or to the women and recite the SISTA motto with the women

Session 2-HIV/AIDS Education:

Goal: Provide factual and statistical information on HIV/AIDS and other sexually transmitted diseases (STDs), correct misconceptions about HIV/AIDS, and discuss the importance of protecting oneself.

During session 2, the facilitators will:

- Distribute a copy of a poem that will be read with and/or to the women
- Review ground rules and expectations
- Review the key concepts of session 1 and discuss the homework exercise from day 1
- Distribute information and handouts on HIV/AIDS and initiate discussions about the information
- Engage the women in a Card Swap game to demonstrate how people get HIV and spread it to other people
- Present a 30 minute video and discuss
- Distribute homework assignments
- Distribute anonymous evaluation forms to assess the second session
- Recite the SISTA motto with the women.

Session 3-Assertiveness Skills Training:

Goal: Teach the distinction among assertive, aggressive and non-assertive behaviors and teach skills to initiate assertive qualities.

During the third session, the facilitator will:

- Distribute a copy of a poem that will be read with and/or to the women
- Review the key concepts of session 2 and discuss the homework exercise from day 2
- Facilitate a discussion on the difference between assertion and aggression
- Distribute a handout on various realistic situations and ask the women to provide examples and consequences of assertive, aggressive and non- assertive responses to the situations; discuss steps in the decision making process
- Distribute homework assignments will be distributed
- Distribute anonymous evaluation forms to assess the third session
- Read the closing poem with and/or to the women and recite the SISTA motto with the women

Session 4-Behavioral Self-Management:

Goal: Decrease participants' anxiety about condom use, demonstrate and role-play how to use condoms and discuss reasons that women do not insist upon using condoms.

During session 4, the facilitator will:

- Distribute a copy of a poem that will be read with and/or to the women
- Review the key concepts of session 3 and discuss the homework exercise from day 3
- Facilitate a discussion on why people do not use condoms and develop a strategy for overcoming these stated obstacles
- Distribute condom packets and lubricant
- Engage the women in a condom-card line-up activity to assess their knowledge of putting on a condom
- Demonstrate how to put on a condom

- Role play negotiation exercises
- Disseminate homework assignments
- Distribute anonymous evaluation forms
- Read the closing poem with and/or to the women and recite the SISTA motto with the women

Session 5-Coping Skills:

Goal: Initiate discussion about coping with life experiences -- including the link between alcohol and AIDS, coping with alcohol and sex, and coping with negative responses. This session also serves as a review of the previous sessions.

During the fifth session, the facilitator will:

- Distribute a copy of a poem that will be read with and/or to the women
- Review the key concepts of session 4 and discuss the homework exercise from day 4
- Review the handouts from previous sessions
- Discuss what coping is and its relationship to alcohol
- Distribute a handout on coping situations
- Inform the group of the booster sessions
- Distribute Anonymous Evaluation forms
- Read the closing poem with and/or to the women and recite the SISTA motto with the women

Booster Sessions: The booster sessions offer participants the opportunity to ask questions, stimulate thinking/knowledge of lessons learned, and reinforce the importance of protecting oneself. The first booster session is held two months after the last session of the intervention. The facilitator will facilitate discussions on (1) how the intervention could be strengthened; (2) whether the participants are using their newly developed skills; and, (3) any challenges that the participants have encountered. In addition, participants will begin designing their graduation ceremony.

The second booster session is held four months after the intervention. Additional questions are answered and the graduation ceremony is held.

RESOURCE REQUIREMENTS

The SISTA intervention should be facilitated by two peer health educators (at least one full time employee). Peers should be of the same race/ethnicity and gender as the target population. The staff should be well versed on HIV transmission and methods for preventing HIV transmission and should have a non-judgmental attitude toward people living with HIV/AIDS. Partnering agencies, if any, should be identified as well as a location to conduct a group session with 10-12 women.

Prior to implementing the intervention the staff should thoroughly review all program materials, plans, and logistics. Specific materials and instructions are provided in the intervention kit. In addition, the staff should copy materials, purchase incentives (described below) and other materials necessary to implement the intervention. Staff should create a culturally sensitive atmosphere and should understand the participant's cultural heritage and institutional barriers. Staff-participant language and dialect matches should also be considered. This will enable the staff to understand how the clients relate to the world.

RECRUITMENT

To encourage participation, SISTA should be publicized as a program for African-American women developed by African-American women that discusses dating, relationships, healthy sexual practices, and works at improving women's ability to effectively communicate with sexual partners. SISTA is a behavioral change intervention targeting women at very high risk for HIV. Clients may be recruited from various venues, including shelters, juvenile court systems, bars, focus groups, jails/prisons, STD clinics or community organizations. Specific cultural needs should be addressed when finding a client population.

Agencies implementing SISTA should see the Procedural Guidance for Recruitment in this document for recruitment strategy options.

Incentives can be used to effectively enhance retention in the SISTA program. For example, bus tokens may be used to provide women with transportation to and from the sessions, childcare may be provided during the sessions. In addition, gift certificates, monetary incentives, and food are all used as positive reinforcements.

PHYSICAL SETTING AND CHARACTERISTICS

Agencies implementing SISTA should choose a location that is easily accessible from public transportation routes. The intervention sessions must be conducted in a secure location such that confidentiality of participants is maintained. It is important that sessions are not interrupted by distractions, such as people entering and exiting the room, or outside noise levels. The location should be able to accommodate 10-12 persons comfortably and privately. In addition, the agency should take into consideration the intervention activities, including role play and role demonstration.

NECESSARY POLICIES AND STANDARDS

Before an agency attempts to implement POL the following policies and procedures should be in place to protect clients, the agency, and the facilitators:

Targeting of Services: Agencies must establish criteria for, and justify the selection of, the target populations. Selection of target populations must be based on epidemiological data,

behavioral and clinical surveillance, and the state or local HIV prevention plan created with input from the state or local community planning group(s).

Informed Consent: Agencies must have a consent form which carefully and clearly explains in accessible language the agency's responsibility and the participants' rights. Individual state laws apply to consent procedures for minors, but at a minimum consent should be obtained from each participant and/or a legal guardian if the participant is a minor or unable to give legal consent. Client participation must always be voluntary and documentation of this informed consent must be maintained in the client's record.

Safety: Agency policies must exist for maintaining safety of workers and clients. Plans for dealing with medical or psychological emergencies must be documented.

Confidentiality: A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from a client or his/her legal guardian must be obtained.

Legal/Ethical Policies: Agencies must know their state laws regarding disclosure of HIV status to sexual and/or needle-sharing partners, and agencies are obligated to inform participants of the potential duty warn and the agency's responsibility if a client tests positive for HIV. Agencies also must inform participants about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.

Linkage of Services: Recruitment and health education and risk reduction must be linked to counseling, testing, and referral services for clients of unknown status, and to care and prevention services for people living with HIV (PLWH). Agencies must develop ways to assess whether and how frequently the referrals made by staff were completed.

Referrals: Agencies must be prepared to supply appropriate referrals to session participants as necessary. Providers must know about referral sources for prevention interventions/counseling (Partner Counseling and Referral Services, or other Health Department/Community Based Organization prevention programs) if clients need additional assistance in decreasing risk behavior.

Data Security: Collect and report data consistent with CDC requirements to ensure data security and client confidentiality.

Cultural Competence: Agencies must strive to offer culturally competent service by being aware of the demographic, cultural, and epidemiological profile of their communities. Agencies should hire, promote, and train staff across all disciplines to be representative of and sensitive to these cultures. In addition, materials and services must be offered in the preferred language of clients/consumers where possible, or translation should be available if appropriate. Agencies should facilitate community and client/consumer involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National*

Standards for Culturally and Linguistically Appropriate Services in Health Care which should be used as a guide for ensuring cultural competency in programs and services. Please see the Cultural Competence section in the introduction of this document (page 9) for standards for developing culturally and linguistically competent programs and services.

Personnel Policies: Agencies conducting recruitment, outreach, and health education and risk reduction, must established a code of conduct. This code should include, but not be limited to, no drug or alcohol use, appropriate behavior with clients, and no loaning or borrowing of money.

Volunteers: If the agency is using volunteers to assist in or conduct this intervention, then the agency should know and disclose how their liability insurance and worker's compensation applies to volunteers. Agencies must ensure that volunteers also receive the same training and are held to the same performance standards as employees. Agencies must also ensure that volunteers sign and adhere to a confidentiality statement. All training should be documented.

QUALITY ASSURANCE

Quality assurance (QA) activities for both providers and participants should be in place when implementing SISTA.

Provider: Facilitators of SISTA should have extensive knowledge of HIV transmission and statistics in their local jurisdictions as well as national statistics. Facilitators should reflect the target population in race and gender and will be expected to deliver the information in a non-threatening and culturally relevant manner. Agencies should have in place a mechanism to ensure all sessions and core elements, as described above, are implemented. QA activities can include direct observation and review of sessions by staff involved in the intervention. The review could focus on the quality (or adherence to the fidelity) of the sessions delivered, and the responsiveness and openness of the women to the facilitator. Facilitators should collect all evaluation forms following each session and ensure participant confidentiality. In addition, facilitators should ensure that all participants are actively participating in each of the sessions. Bi-monthly meetings with supervisors to discuss progress and/or opportunities for change are encouraged.

Participants: The participants' satisfaction with the intervention and their comfort should be assessed during each session. Evaluation forms are provided in the intervention box and should be disseminated during each session. In addition, agencies can develop their own forms to assess participant satisfaction.

MONITORING AND EVALUATION

Evaluation and monitoring intervention activities include the following:

- Collect and report standardized process and outcome monitoring data consistent with CDC requirements;
- Enter and transmit data for CDC-funded services on PEMS (Program Evaluation Monitoring System), a CDC-provided browser-based system, or describe plans to make a local system compatible with CDC's requirements;
- Collect and report data consistent with the CDC requirements to ensure data quality and security and client confidentiality;
- Collaborate with CDC in assessing the impact of HIV prevention activities by participating in special projects upon request.
- Collect and report data on the following indicators:
    - **I.A-** The mean number of outreach contacts required to get one person with unknown or negative serostatus to access counseling and testing.
    - **I.B-** The proportion of person who access counseling and testing from each of the following interventions: individual level interventions and group level interventions.
    - **I.C-** Proportion of persons that completed the intended number of sessions for each of the following interventions: individual level interventions (ILI) and group level interventions (GLI).
    - **III.B-** Proportion of persons at very high risk for HIV infection that completed the intended number of sessions for each of the prevention interventions supported by this program announcement.
    - **IV.A-** Proportion of client records with the CDC-required demographic and behavioral risk information.
    - **V.A -** The mean number of outreach contacts required to get a person (living with HIV, their sex partners and injection drug-using contacts or at very high risk for HIV infection) to access referrals made under this program announcement.

KEY ARTICLES AND RESOURCES

[1]DiClemente RJ, Wingood GM. A Randomized controlled trial of an HIV sexual risk reduction intervention for young African American women. The Journal of the American Medical Association, 1995, 274(16), 1271-1276.

[2]Wingood GJ, DiClemente RJ. Partner influences and gender-related factors associated with noncondom use among young adult African American women. American Journal of Community Psychology, 1998, 26(1), 29-49.

[3]Wingood GM, DiClemente RJ. Application of the theory of gender and power to examine HIV-related exposures, risk factors, and effective interventions for women. Health Education & Behavior, 2000, 27(5), pages 539-565.

The SISTA Project intervention box was developed by Sociometrics. For more information on receiving training on this intervention, please visit www.effectiveinterventions.org.

PROCEDURAL GUIDANCE FOR IMPLEMENTATION OF MANY MEN, MANY VOICES

CBO PROGRAM ANNOUNCEMENT RFP 04064
DEPARTMENT OF HEALTH AND HUMAN SERVICES

DESCRIPTION OF MANY MEN, MANY VOICES

Many Men, Many Voices (MMMV) is a six- or seven-session, group level HIV/STD prevention intervention for gay and bisexual men of color adapted from the Behavioral Self-Management and Assertion Skills intervention[1] (now called Partners in Prevention) developed by the Center for AIDS Intervention Research (CAIR) in the Department of Psychiatry and Behavioral Medicine at the Medical College of Wisconsin. This intervention has been packaged by CDC's Diffusion of Effective Behavioral Interventions (DEBI) project and information on obtaining the intervention training and materials is available at www.effectiveinterventions.org.

The original model intervention was condensed from twelve sessions to six (with an optional seventh) but individual sessions were expanded from 90 minutes to 2-3 hours. It was adapted and tailored using the strategies outlined in the *Procedural Guidance,* to address behavioral influencing factors specific to gay men of color including cultural/social norms, and values and sexual relationship dynamics. The adaptation, tailoring and implementation of this intervention were done in partnership with Men of Color Health Awareness (MOCHA), People of Color in Crisis (POCC) and the Center for Health and Behavioral Training (CHBT).

Many Men Many Voices is designed to be facilitated by a peer in groups of 6-12 participants. The three hour sessions aim to foster positive self identity, educate participants about their HIV/AIDS risk and teach assertiveness skills. For participants who are unaware of their HIV status, the benefits of knowledge of serostatus should be addressed, and referral for counseling and testing should be provided when appropriate. The program utilizes behavioral skills practice, group discussions, role play and lectures in highly interactive sessions.

In the original Partners in Prevention intervention, gay men who participated reduced their frequency of unprotected anal intercourse and increased their use of condoms significantly more than men in the control condition.

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements are those components that are critical features of an intervention's or strategy's intent and design and that are thought to be responsible for its effectiveness. Consequently, they must be maintained without alteration to ensure program effectiveness. Core elements are

derived from the behavioral theory upon which the intervention or strategy is based. They are essential to the implementation of the program and cannot be ignored, added to, or changed. There are 5 core elements of MMMV:

1) Educate clients about HIV risk and sensitize to personal risk.

2) Develop risk reduction strategies.

3) Train in behavioral skills.

4) Train in sexual assertiveness.

5) Provide social support and relapse prevention.

Key Characteristics are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations to meet the needs of the target population and ensure cultural appropriateness of the strategy. MMMV has the following key characteristics:

- Foster positive identity development for gay men of color by exploring the dual identity culture of gay men of color, addressing social and cultural norms within racial/ethnic communities, exploring positive and negative peer influences, setting self-standards and clarifying values
- Discuss sexual roles and risks, addressing knowledge of HIV transmission risk and exploring beliefs about those risks
- Address perceived personal risk and personal susceptibility for HIV infection as well as the perceived benefits and outcomes of remaining HIV negative
- Increase skills and self-efficacy for protective behaviors and intentions to engage in those behaviors
- Explore sexual relationship dynamics including power dynamics
- Address the importance of peer support and social influence on maintaining healthy behaviors

Procedures describe the activities that make up the content of the intervention and provide direction to agencies or organizations regarding the implementation of the intervention. Procedures for implementing MMMV follow.

Many Men, Many Voices is implemented by one or two group level facilitators who are trained in the specific content of each group session. The facilitators are responsible for coordinating all activities and organizing all aspects of the intervention. At least one of the facilitators must be a gay or bisexual male of color.

The intervention consists of educational materials for distribution which may be used to recruit persons at risk into the group. Outreach by project staff is also necessary to recruit gay/bisexual men of color into the intervention sessions. The intervention was not designed for heterosexual males and they should not be included in the sessions. Men of color who have sex with other

men but do not identify as "gay" or "bisexual" are appropriate for the intervention as long as they are willing to discuss the STD and HIV risks of male to male sexual behaviors and the risk reduction methods that constitute safer sex.

The original 12 session intervention[1] was tailored and condensed into the 6 sessions of Many Men, Many Voices. An optional seventh session may be added at the discretion of the group facilitators. The seven sessions address specific influencing factors in a purposeful sequence including:

Session 1: The Dual Identity Culture of Gay Men of Color
Session 2: HIV Prevention for Gay Men of Color – Sexual Roles and Risks
Session 3: HIV Risk Assessment and Prevention Options
Session 4: Intentions to Act and Capacity to Change
Session 5: Partner Selection, Communication and Negotiation
Session 6: Social Support and Problem Solving to Maintain Change
Session 7 (optional): Building a Healthy Community

The original 75-90 minute sessions were tailored and expanded to 2-3 hour Many Men, Many Voices sessions. Sessions contain very little presentation of information, and instead are highly interactive and allow for the clients to gain knowledge experientially (for example, through the use of educational games, and other exercises). Through their formative evaluation, the agencies that adapted the intervention found that the African American gay/bisexual men that they served were more inclined to attend 7 sessions of 2-3 hours each rather than 12 sessions of 75-90 minutes. An agency may conduct its own formative evaluation to determine whether participation rates would increase or decrease relative to the number of sessions and the length of each session. Whether the agency chooses to conduct fewer sessions of longer length or to conduct more sessions of shorter length should be based on client needs and client convenience. The intervention may also be condensed into a weekend retreat format, covering the 18-21 hours of intervention materials over the course of a single weekend. The entire content of the sessions constitutes the core elements of this intervention and so the entire content must be covered to implement the intervention with fidelity.

RESOURCE REQUIREMENTS

The agency should hire at least one full-time group facilitator. A second facilitator can be hired at a full- or part-time level depending on the level of need in the community. Group facilitation skills are necessary and should be a consideration in hiring staff or in initial training of staff. Facilitators are responsible for all aspects of the program including recruitment, group facilitation, record keeping, quality assurance, and monitoring and evaluation. Therefore it is recommended that each group facilitator run no more than two concurrent groups. An administrative employee of the community based organization typically supervises the group facilitator(s).

In addition to staff of the intervention, materials that are needed to conduct the intervention include markers, easel charts and newsprint, a VCR and television, an overhead projector, masking tape, poster boards, and clothespins.

RECRUITMENT

The target population for Many Men Many Voices is gay and bisexual men of color. Recruitment into the intervention sessions will include outreach to venues where MSM of color can be reached. Printed materials may also be used to recruit MSM of color into the intervention. The group facilitators generally recruit participants, but clients may also be referred to the groups through other programs. It is best if the group facilitators interview potential group members prior to the first group to determine if the individual is appropriate for the group.

Agencies wishing to implement Many Men, Many Voices should review the Procedural Guidance for Recruitment in order to choose a recruitment strategy that will work in the setting in which they plan to implement MMMV.

PHYSICAL SETTING CHARACTERISTICS

Agencies implementing Many Men Many Voices should choose a location that is easily accessible from public transportation routes and is also in communities where young gay/bisexual men of color live, work and socialize. The groups are usually held at the CBO, but can be held in other locations. Ideally the space should have comfortable seating for discussions. The intervention sessions must be conducted in a private and secure location so that confidentiality of participants can be maintained. It is crucial that intervention sessions are not interrupted by distractions such as people entering and exiting the room, or outside noise levels.

NECESSARY POLICIES AND STANDARDS

Before an agency attempts to implement MMMV the following policies and procedures should be in place to protect participants, the agency, and the MMMV program team:

Targeting of Services: Agencies must establish criteria for, and justify the selection of, the target populations. Selection of target populations must be based on epidemiological data, behavioral and clinical surveillance, and the state or local HIV prevention plan created with input from the state or local community planning group(s).

Informed Consent: Agencies must have a consent form which carefully and clearly explains in accessible language the agency's responsibility and the participants' rights. Individual state laws apply to consent procedures for minors, but at a minimum consent should be obtained from each participant and/or a legal guardian if the participant is a minor or unable to give legal consent. Client participation must always be voluntary and documentation of this informed consent must be maintained in the client's record.

Safety: Agency policies must exist for maintaining safety of workers and clients. Plans for dealing with medical or psychological emergencies must be documented.

Confidentiality: A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from a client or his/her legal guardian must be obtained.

Legal/Ethical Policies: Agencies must know their state laws regarding disclosure of HIV status to sexual and/or needle-sharing partners, and agencies are obligated to inform participants of the potential duty warn and the agency's responsibility if a client tests positive for HIV. Agencies also must inform participants about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.

Linkage of Services: Recruitment and health education and risk reduction must be linked to counseling, testing, and referral services for clients of unknown status, and to care and prevention services for people living with HIV (PLWH). Agencies must develop ways to assess whether and how frequently the referrals made by staff were completed.

Referrals: Agencies must be prepared to supply appropriate referrals to session participants as necessary. Providers must know about referral sources for prevention interventions/counseling (Partner Counseling and Referral Services, or other Health Department/Community Based Organization prevention programs) if clients need additional assistance in decreasing risk behavior.

Data Security: Collect and report data consistent with CDC requirements to ensure data security and client confidentiality.

Cultural Competence: Agencies must strive to offer culturally competent service by being aware of the demographic, cultural, and epidemiological profile of their communities. Agencies should hire, promote, and train staff across all disciplines to be representative of and sensitive to these cultures. In addition, materials and services must be offered in the preferred language of clients/consumers where possible, or translation should be available if appropriate. Agencies should facilitate community and client/consumer involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care* which should be used as a guide for ensuring cultural competency in programs and services. Please see the Cultural Competence section in the introduction of this document (page 9) for standards for developing culturally and linguistically competent programs and services.

Personnel Policies: Agencies conducting recruitment, outreach, and health education and risk reduction, must established a code of conduct. This code should include, but not be limited to, no drug or alcohol use, appropriate behavior with clients, and no loaning or borrowing of money.

Volunteers: If the agency is using volunteers to assist in or conduct this intervention, then the agency should know and disclose how their liability insurance and worker's compensation applies to volunteers. Agencies must ensure that volunteers also receive the same training and are held to the same performance standards as employees. Agencies must also ensure that volunteers sign and adhere to a confidentiality statement. All training should be documented.

QUALITY ASSURANCE

Quality assurance (QA) activities for both facilitators and participants should be in place when implementing MMMV:

Facilitator: Training for facilitators should address the following three areas: (1) completion of a training workshop, including review of the intervention theory and materials; (2) participation in practice sessions; and (3) observed co-facilitation of groups, including practice of mock intervention sessions. Agencies should have in place a mechanism to ensure that all session protocols are followed as written. QA activities can include observation and review of sessions by key staff and supervisors involved with the activity. This review should focus on adherence to session content, use of interactive techniques; accessibility and responsiveness to expressed participant needs; and important process elements (e.g., time allocation, clarity of presentation). Selected intervention record reviews should focus on assuring that consent forms (signed either by the participant if he/she is over 18 or emancipated, or by a legal guardian) are included for all participants, and session notes are of sufficient detail to ensure that clients are participating actively.

Participant: Participants' satisfaction with the intervention and their comfort should be assessed at the final session of each module. Process monitoring systems should also track the number of sessions each participant attends, as well as reasons for non-attendance.

MONITORING AND EVALUATION

Evaluation and monitoring intervention activities include the following:

- Collect and report standardized process and outcome monitoring data consistent with CDC requirements;
- Enter and transmit data for CDC-funded services on PEMS (Program Evaluation Monitoring System), a CDC-provided browser-based system, or describe plans to make a local system compatible with CDC's requirements;
- Collect and report data consistent with the CDC requirements to ensure data quality and security and client confidentiality;
- Collaborate with CDC in assessing the impact of HIV prevention activities by participating in special projects upon request.
- Collect and report data on the following indicators:
    - **I.A-** The mean number of outreach contacts required to get one person with unknown or negative serostatus to access counseling and testing.

- **I.B-** The proportion of person who access counseling and testing from each of the following interventions: individual level interventions and group level interventions.
- **I.C-** Proportion of persons that completed the intended number of sessions for each of the following interventions: individual level interventions (ILI) and group level interventions (GLI).
- **III.B-** Proportion of persons at very high risk for HIV infection that completed the intended number of sessions for each of the prevention interventions supported by this program announcement.
- **IV.A-** Proportion of client records with the CDC-required demographic and behavioral risk information.
- **V.A -** The mean number of outreach contacts required to get a person (living with HIV, their sex partners and injection drug-using contacts or at very high risk for HIV infection) to access referrals made under this program announcement.

KEY ARTICLES AND RESOURCES

[1]Kelly JA, St. Lawrence JS, Hood HV, Brasfield TL. (1989). Behavioral intervention to reduce AIDS risk activities. Journal of Consulting and Clinical Psychology, 57(1), pp. 60-67.

PROCEDURAL GUIDANCE FOR IMPLEMENTATION OF COMMUNITY PROMISE

CBO PROGRAM ANNOUNCEMENT RFP 2003-N-00895
DEPARTMENT OF HEALTH AND HUMAN SERVICES

DESCRIPTION OF COMMUNITY PROMISE

Community PROMISE is a community-level STD/HIV prevention intervention that relies on the outreach work of peer advocates from the target community to deliver role model stories to members of the target population. Peer outreach is the main vehicle of delivery for the intervention, and the work of peer advocates is one of the core elements of the intervention. Community PROMISE is an acronym for Peers Reaching Out and Modeling Intervention Strategies. This intervention has been packaged by CDC's Diffusion of Effective Behavioral Interventions (DEBI) project and information on obtaining the intervention training and materials is available at www.effectiveinterventions.org.

Community PROMISE is adapted by each community and thus can target a wide variety of high risk populations, including injection drug users, their sex partners, people living with HIV, sex workers, non-gay identified men who have sex with men, high risk youth, and others. Community PROMISE has used role model stories to disseminate many types of messages that address the prevention needs of these different populations. The prevention messages in role model stories can be used to encourage peers to seek HIV counseling and testing services, partner counseling and referral services, and other prevention and treatment services.

The impact of Community PROMISE extends beyond the individuals who are involved in the intervention, changing behavior within a community by influencing attitudes, beliefs and norms through social networks within those communities. Community PROMISE is grounded in several behavioral theories, including the Stages of Change model.

Results from a 3-year cross-sectional study found Community PROMISE to be effective in five cities across the United States in promoting community-wide progress toward consistent HIV risk reduction. PROMISE affected movement toward consistent condom use with main and non-main partners and increased condom carrying among those in the intervention compared to comparison communities. In addition, individuals in the intervention had higher stage-of-change scores for condom and bleach use than those in the comparison group.[1,2]

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements are those components that are critical features of an intervention or strategy's intent and design and that are thought to be responsible for its effectiveness. Consequently, they must be maintained without alteration to ensure program effectiveness. Core elements are derived from the behavioral theory upon which it the intervention or strategy is based. They are essential to the implementation of the program and cannot be ignored, added to, or changed. Community PROMISE has 3 core elements:

1) Community Identification Process: Community identification is a formative research process focused on intervention development and designed to assist in identifying, prioritizing, accessing, and understanding groups targeted for intervention.

2) Role Model Stories: Role model stories are the "heart" of printed materials distributed throughout the community. They are personal accounts from individuals in the target population who have already made some risk-reduction behavior change.

3) Peer Advocates: Peer advocates are recruited and trained to disseminate role model stories.

Key Characteristics are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations to meet the needs of the target population and ensure cultural appropriateness of the strategy. Key characteristics of Community PROMISE are:

- Discussing the appropriateness of the intervention and necessary program resources with stakeholders
- Networking with other agencies and community organizations to avoid duplicating efforts, to elicit support and cooperation, and to find referral sources
- Forming a community advisory board to foster community commitment to the project and to develop a plan for accessing at-risk community members
- Assessing the community to develop a clear understanding of the composition of the target population, to identify specific risk behaviors and the contexts in which they occur, to discover the meaning of risk practices to the population, and to learn what members of the population believe are appropriate and relevant risk-reduction messages
- Reviewing recent epidemiologic data
- Interviewing agency staff and members of at-risk populations
- Conducting community mapping and focus groups specifically for this assessment
- Identifying the most prevalent stage(s) of change among at-risk populations for various risk reduction practices
- Assembling the information and preparing a comprehensive report
- Using community assessment information to decide on a specific target risk-reduction behavior
- Recruiting members of the target population (e.g., current or former commercial sex workers) or credible outreach staff to be peer advocates

- Training peer advocates for 1 to 3 hours on program goals, HIV/AIDS, and use of role model stories
- Establishing a system for maintaining advocates' commitment
- Recruiting, screening, and interviewing community members who are members of the local target population and who are performing behaviors to avoid HIV; their safer sex decisions will form the basis for role model stories
- Writing and locally pre-testing brief (400 words or less) role-model stories to address the target population's targeted risk behavior based on examples available in the intervention kit.
- Including in role-model stories relevant and realistic circumstances, the person's initial stage of change, motivator, action step, resolved challenge, and positive consequences of making a particular behavior change
- Having peer advocates distribute stage-appropriate stories to their peers and reinforce the stories' messages in conversation
- Having peer advocates distribute condoms, lubricants, and/or bleach kits along with the role-model stories
- Having each advocate distribute role model stories and risk reduction supplies to 10 to 20 peers each week

Procedures describe the activities that make up the content of the intervention and provide direction to agencies or organizations regarding the implementation of the intervention. Procedures for implementing Community PROMISE follow below:

Community Identification (CID) Process

Community identification is a formative research process focused on intervention development and designed to assist in identifying, prioritizing, accessing, and understanding groups targeted for intervention. Methods used to collect information include focus groups, key informant and gatekeeper interviews, community observation, and surveys of internal staff and external sources. Community identification helps to accurately define problems and identify solutions, reveals community norms and the community's stage(s) of change, helps develop trust, informs intervention approaches, and identifies peers who can be involved in the intervention outreach. A key component of community identification is mobilizing the community to support and participate in the intervention. For example, local shops can make available prevention and other materials related to the intervention.

In preparation for the CID process, agencies identify which formative evaluation methods to use and develop or adapt the necessary instruments, such as interviews, community observation protocol, focus group script and materials, informed consent, and field safety guidelines. Staff are hired or current staff trained to conduct the formative evaluation process. The staff debriefs on the findings and makes decisions and develops implementation plan accordingly. Staff outreach workers play a role in recruiting members of the target population for in-depth interviews, identifying possible role models to be used in role model stories and are, in general, liaisons between peer volunteers, members of the target population and other agency staff. The primary duty of outreach staff is to train and supervise the peer volunteers.

Role Model Stories (RMS)

Role model stories comprise the "heart" of printed materials distributed throughout the community. They are personal accounts from individuals in the target population who have already made some risk-reduction behavior change. Developed from interviews conducted by outreach workers with target population members, the stories explain how and why the role model took steps to practice HIV risk-reduction behaviors and the positive effect it has had on their lives. The stories depict movement from one specific stage of change to the next, and this initial stage matches the predominant stage of change in the target population. Role model stories contain the behavior change message to deliver to the target population through outreach by peer advocates or messengers.

After staff is trained on interviewing (CID) for RMS, potential role models are recruited and screened. Appropriate role models who have demonstrated a reduced risk behavior are interviewed and the story is written and edited from the interview transcript. A format and layout for the story is developed and the product is reviewed and edited by staff. Sample stories are included in the intervention kit and can be used as models. Once approved, the publication is printed and combined with prevention materials, if used.

Peer Advocates

Peer advocates are recruited and trained to disseminate role model stories. The trained peer advocates use conversation to reinforce the messages in the role model stories. In their interactions with the community, the peer advocates encourage other target population members to read and talk about the stories within their own social network. By doing this, peer advocates assist their peers in more immediately relating to the content of the role model stories and help encourage peers to engage in risk-reduction or health-enhancing behaviors. For example, if the role model story demonstrates how the main character got tested for HIV, then the peer advocate encourages the target population member to think about that behavior change. Peer advocates also distribute prevention materials such as condoms and bleach.

Once peer advocates are recruited, screened and trained, they work with staff outreach workers and other staff to identify areas for distribution of RMS and prevention materials. Peer advocates distribute materials to and interact with the target population at times and frequencies agreed upon with the outreach worker. Regular meetings, trainings and appreciation events for peers are held at the agency and incentives are provided to them.

RESOURCE REQUIREMENTS

The minimum human resources required for Community PROMISE are a program manager at 25-100% time, one to several outreach workers at 100% time, role model story writing and production staff at 40-50% time and a support staff member at 50% time. The staff number and time can be increased depending on the size of the program. Peer advocates are not paid and work on a volunteer basis. However incentives are provided to them regularly, and they should have input on what type of incentives best suit them.

Other material resources include:

- Computer, printer, and software for word processing, desktop publishing, and data management and analysis
- Telephones, fax machine, copier, and equipment maintenance
- Digital camera (if you will be doing your own pictures for the publications) or photographer and scanner for role-model publications
- Production and printing
- Transportation for outreach workers
- Incentives for peer advocates (hats, hygiene kits, etc)
- Prevention materials to package with printed materials

RECRUITMENT

Recruitment of participants for Community PROMISE occurs at several levels. First, there is recruitment of individuals to participate in the community identification process. These individuals are invited to share their knowledge of the target population in focus groups, interviews or surveys.

Second, target population members are recruited by outreach workers to be interviewed, in order to create role model stories. These individuals can be identified during the community identification process or through referrals by outreach workers, STD/HIV test sites and other people who interact with members of the target population.

A third level of recruitment is of peers from the target population to distribute role model stories and prevention materials and reinforce prevention messages. Peers can be identified and recruited during the community identification process or through interaction with target population and community members. They can also be recruited through street outreach, at key sites such as local hang-outs, and through referral from community members.

Fourth, target population members are recruited by peer advocates to be recipients of role model stories and prevention materials. Depending on the message in the role model story, peer advocates recruit peers into counseling, testing and referral services, and other prevention and treatment services. The community identification process and the peer's familiarity with the target population environment will identify the proper venues and methods for role model story and materials distribution and interaction between the peer and target population.

PHYSICAL SETTING CHARACTERISTICS

Community PROMISE takes place in several settings, depending on the intervention activity. The community identification process occurs in community locations such as stores, bars, on the street, or even in agency offices. The interviewing of target population members by outreach workers or staff for role model stories occurs in a private setting such as agency offices or in community locations. The distribution of role model stories and materials occurs in locations

identified as appropriate in the community identification process. These are primarily venues where peer advocates find and work with the target population.

NECESSARY POLICIES AND STANDARDS

Before an agency attempts to implement Community PROMISE, the following policies and procedures should be in place to protect participants and the agency:

Targeting of Services: Agencies must establish criteria for, and justify the selection of, the target populations. Selection of target populations must be based on epidemiological data, behavioral and clinical surveillance, and the state or local HIV prevention plan created with input from the state or local community planning group(s).

Safety: Agency policies must exist for maintaining safety of workers and clients. Plans for dealing with medical or psychological emergencies must be documented.

Confidentiality: A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from a client or his/her legal guardian must be obtained.

Linkage of Services: Recruitment and health education and risk reduction must be linked to counseling, testing, and referral services for clients of unknown status, and to care and prevention services for people living with HIV (PLWH). Agencies must develop ways to assess whether and how frequently the referrals made by staff were completed.

Data Security: Collect and report data consistent with CDC requirements to ensure data security and client confidentiality.

Cultural Competence: Agencies must strive to offer culturally competent service by being aware of the demographic, cultural, and epidemiological profile of their communities. Agencies should hire, promote, and train staff across all disciplines to be representative of and sensitive to these cultures. In addition, materials and services must be offered in the preferred language of clients/consumers where possible, or translation should be available if appropriate. Agencies should facilitate community and client/consumer involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care* which should be used as a guide for ensuring cultural competency in programs and services. Please see the Cultural Competence section in the introduction of this document (page 9) for standards for developing culturally and linguistically competent programs and services.

Personnel Policies: Agencies conducting recruitment, outreach, and health education and risk reduction, must established a code of conduct. This code should include, but not be limited

to, no drug or alcohol use, appropriate behavior with clients, and no loaning or borrowing of money.

Volunteers: If the agency is using volunteers to assist in or conduct this intervention, then the agency should know and disclose how their liability insurance and worker's compensation applies to volunteers. Agencies must ensure that volunteers also receive the same training and are held to the same performance standards as employees. Agencies must also ensure that volunteers sign and adhere to a confidentiality statement. All training should be documented.

QUALITY ASSURANCE

Community PROMISE is a community-level intervention that relies on the outreach work of peer advocates and the role model stories of members of the target population. It is naturally adapted and tailored to each unique community environment to best fit the community's needs and culture. Agency resources will determine how the intervention is implemented and what modifications, if any need to be made to fit within budget limits. The intervention training and supporting materials provide suggestions for how agencies can adapt the intervention. However, the core elements are essential components of the program that can not be modified in any manner.

A strong component of quality assurance is preparing a plan to implement Community PROMISE. Developing a comprehensive implementation plan will facilitate understanding and "buy-in" from key stakeholders and increase the likelihood the intervention runs smoothly. Quality assurance on this intervention also requires that someone at the agency will provide hands-on leadership and guidance for the intervention—from preparation through institutionalization. Also, a decision maker is needed in the agency who will provide higher-level support, including securing resources and advocating for Community PROMISE, from preparation to institutionalization.

Fidelity to the core elements of Community PROMISE is essential to assure the quality and effectiveness of the intervention. Throughout implementation, it is necessary to determine whether staff is delivering the intervention with fidelity to the core elements. The technical assistance manual contains a quality assurance tool to check fidelity to the core elements. In addition, training on the intervention and supporting materials such as the implementation manual and technical assistance manual provide implementing agencies with quality assurance tools to monitor implementation and measure fidelity. For example, the implementation manual contains a table detailing each task from the planning stage to the evaluation stage and listing the resources, skills and knowledge needed for tasks.

It is also necessary to identify and address any issues to assure the intervention is meeting the needs of agency clients and staff. Staff who are implementing Community PROMISE can develop their own Quality Assurance Checklist to help staff identify, discuss and solve problems in successfully implementing the intervention.

Evaluation is an important program management and quality assurance tool. Community PROMISE focuses on formative evaluation in the community identification process, process

monitoring and evaluation to assess the implementation process, and outcome monitoring to identify changes in the target population. The implementation manual in the intervention kit provides guidance and instruments such as interview guides, surveys, and tracking forms that can be adapted and used.

MONITORING AND EVALUATION

Evaluation and monitoring intervention activities include the following:

- Collect and report standardized process and outcome monitoring data consistent with CDC requirements;
- Enter and transmit data for CDC-funded services on PEMS (Program Evaluation Monitoring System), a CDC-provided browser-based system, or describe plans to make a local system compatible with CDC's requirements;
- Collect and report data consistent with the CDC requirements to ensure data quality and security and client confidentiality;
- Collaborate with CDC in assessing the impact of HIV prevention activities by participating in special projects upon request.
- Collect and report data on the following indicators:
    - **I.A-** The mean number of outreach contacts required to get one person with unknown or negative serostatus to access counseling and testing.
    - **I.B-** The proportion of person who access counseling and testing from each of the following interventions: individual level interventions and group level interventions.
    - **IV.A-** Proportion of client records with the CDC-required demographic and behavioral risk information.
    - **V.A -** The mean number of outreach contacts required to get a person (living with HIV, their sex partners and injection drug-using contacts or at very high risk for HIV infection) to access referrals made under this program announcement.

KEY ARTICLES AND RESOURCES

[1]The CDC AIDS Community Demonstration Projects Research Group (1999). Community-Level HIV Intervention in 5 Cities: Final Outcome Data from the CDC AIDS Community Demonstration Projects. American Journal of Public Health. 89:336-345.

[2]Corby NH, Wolitski RJ. (Eds.). (1997). Community HIV prevention: The Long Beach AIDS Community Demonstration Project. Long Beach, CA: The University Press, California State University, Long Beach.

For more information on the Community PROMISE intervention, training and technical assistance, or to get your name on a list for a future training, please go to the website: www.effectiveinterventions.org.